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DUKING IT OUT: BEATING THE COMPLETE PREEMPTION OF ERISA UNDER
DUKES V. U.S. HEALTHCARE, INC.

INTRODUCTION

Darryl Dukes was a member of U.S. Healthcare, Inc., a health maintenance organization (HMO), through an employer-sponsored health plan.\(^1\) When he began to feel sick, Darryl visited his primary physician under his U.S. Healthcare policy.\(^2\) Several days later, his physician performed surgery and ordered several blood studies.\(^3\) However, the U.S. Healthcare hospital refused, without explanation, to do the tests.\(^4\) The next day, Mr. Dukes went to a second U.S. Healthcare physician who also ordered the blood tests which were subsequently performed.\(^5\) Mr. Dukes died shortly after the tests had been conducted.\(^6\) Mrs. Dukes alleged her husband’s condition could have been detected if the tests had been performed in a timely manner.\(^7\)

Linda Visconti was also a member of U.S. Healthcare through an employer-sponsored plan.\(^8\) During her pregnancy, Mrs. Visconti developed signs of preeclampsia.\(^9\) She gave birth to a stillborn child.\(^10\) She subsequently claimed her doctor negligently failed to diagnose the symptoms.\(^11\)

Both Mrs. Dukes and Mrs. Visconti sued U.S. Healthcare in state court for the negligence of its doctors under an ostensible agency theory, a form of vicarious liability.\(^12\) U.S. Healthcare removed both cases to federal court, claiming the causes of action arose under federal law because the claims were “directed to the

\(^{\text{2. See id.}}\)
\(^{\text{3. See id.}}\)
\(^{\text{4. See id.}}\)
\(^{\text{5. See id.}}\)
\(^{\text{6. See id.}}\)
\(^{\text{7. See id.}}\)
\(^{\text{8. See id. at 353.}}\)
\(^{\text{9. See id.}}\)
\(^{\text{10. See id.}}\)
\(^{\text{11. See id.}}\)
\(^{\text{12. See id. at 352-53.}}\)
structure and operation of the employer benefit plan[s].”13 Both federal district courts supported U.S. Healthcare’s arguments, ruling removal was appropriate because the Employee Retirement Income Security Act (ERISA) completely preempted the negligence claims.14

In Dukes v. U.S. Healthcare, Inc.,15 the Third Circuit combined the Viscontis’ and Mrs. Dukes’ claims into one action and reversed the two district courts’ rulings.16 The Third Circuit held that Mrs. Visconti’s and Mrs. Dukes’ vicarious liability claims against U.S. Healthcare for the negligence of its physicians were not completely preempted by ERISA’s Section 502 civil enforcement provision.17 The Third Circuit said the automatic removal to federal court was in error and remanded the action to state court to determine if Section 514 of ERISA preempted the plaintiffs’ claims.18

Federal courts have uniformly held that ERISA preempts direct liability claims, such as the negligent selection and retention of physicians and negligence involving utilization review against managed care organizations administering employer-sponsored plans.19 However, federal courts are split as to whether ERISA preempts vicarious liability claims against managed care organizations managing employer-sponsored plans.20 Vicarious liability claims against managed care organizations are the latest challenge to ERISA’s complete preemption doctrine.21 The Third Circuit was the first court to rule that a medical malpractice claim against a managed care organization, based on vicarious liability, was not completely preempted under Section 502 of ERISA.22 The Dukes decision is a vital step toward ensuring that employer-sponsored managed

13. Id. (citing Dukes App. at 31).
14. See id. at 353.
17. See id. at 351-52.
18. See id. at 352, 361.
19. See infra notes 146-53 and accompanying text.
20. See infra notes 154-61 and accompanying text.
22. See Dukes, 57 F.3d at 351-52.
care plans face the same liability as other medical providers for the actions of their employees or agents.\textsuperscript{23}

Part I of this Note examines the development of managed care organizations. Part II traces the history of liability for medical institutions. Part III explains the sections of ERISA involved in malpractice claims. Part IV describes how ERISA is used as a defense to malpractice liability. Part V discusses the rationale and policy implications behind the \textit{Dukes v. U.S. Healthcare, Inc.} ruling, and Part VI reviews the decision of courts that have incorporated the \textit{Dukes} logic for determining the liability of employer-funded managed care organizations. Finally, this Note concludes by discussing the novelty of the \textit{Dukes} analysis.

I. THE RISE OF MANAGED CARE ORGANIZATIONS

A. Rising Costs

Due to the continual rise in healthcare costs over the past twenty years,\textsuperscript{24} the manner in which healthcare services are delivered and reimbursed is dramatically changing.\textsuperscript{25} In reaction to escalating costs, government and corporate purchasers of healthcare benefits have adopted cost containment measures that limit services, hospitalization, and the use of costly technology.\textsuperscript{26} “This type of external review [of medical services] is sometimes referred to as managed care.”\textsuperscript{27}

Managed care has grown rapidly over the last ten years.\textsuperscript{28} In 1984, health plans that required precertification prior to surgery covered only five percent of employees while in 1986 plans requiring precertification covered over twenty percent of employees.\textsuperscript{29}

\begin{itemize}
\item \textsuperscript{23} See generally \textit{id.;} Shah, supra note 21, at 1575 (supporting tort liability for HMOs).
\item \textsuperscript{24} BARRY R. FURROW ET AL., \textit{HEALTH LAW: CASES, MATERIALS AND PROBLEMS} 661 (2d ed. 1991) (“Per capital spending on medical care has grown from $82 per year in 1950 to $211 in 1965 to $2511 in 1990.”).
\item \textsuperscript{26} See Jack K. Kilcullen, \textit{Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability}, 22 \textit{AM. J.L. & MED.} 7, 23 (1996); Parise, supra note 25.
\item \textsuperscript{28} See \textit{id.} at 883.
\item \textsuperscript{29} See Jon Gabel et al., \textit{The Changing World of Group Health Insurance}, \textit{HEALTH
B. Forms of Managed Care

Managed care organizations (MCOs) are structured in several forms, each differing in the amount of control exerted over physicians, their medical decisions, and the patients' choice of doctors.30 The two predominant structures in MCOs are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).31

1. HMOs

HMOs32 are organized in three basic forms: (1) the staff model; (2) the independent practice association (IPA); and (3) the group model.33 Under the staff model, the "HMO directly employs salaried physicians and other providers and often owns or leases its own healthcare facilities."34 In the IPA model, the HMO contracts with a physicians' association to deliver healthcare to HMO members.35 Then the association contracts with private practice physicians, who provide services to HMO members but may also treat non-HMO patients.36 Finally, under the group model, the HMO contracts with physicians' partnerships and corporations to deliver prepaid medical services to HMO members.37 The physicians' corporations and partnerships generally pay their member physicians a salary and provide incentives to keep costs low.38

AFF. 48, 59 (Summer 1988).

30. See Parise, supra note 25, at 977-81.
32. HMOs are prepaid healthcare delivery systems in which subscribers pay "a pre-determined, per capita premium regardless of the amount or cost of medical services actually used." FURROW ET AL., supra note 24, at 472. Members are generally restricted to obtaining prepaid healthcare from HMO physicians who were either "direct employees" or members of the physicians' associations with whom the HMO contracts. See id.
33. Chittenden, supra note 31, at 452.
34. Id.
35. See FURROW ET AL., supra note 24, at 472.
36. See Chittenden, supra note 31, at 452.
37. See FURROW ET AL., supra note 24, at 472.
38. See id.
2. **PPOs**

In a PPO, the "physicians, hospitals and other medical providers contract [with the HMO] to provide healthcare services" to the members on a predetermined, discounted fee arrangement.\(^\text{39}\) The PPO members pay premiums "to the organization which, in turn, reimburses the providers directly for their services."\(^\text{40}\) The participants are not required to use the preferred physicians, but if they do, they receive lower deductibles, higher benefit levels, and reduced or non-existent coinsurance.\(^\text{41}\)

There are three basic PPO models: "provider sponsored, carrier sponsored, and broker model."\(^\text{42}\) In the provider-sponsored plan, providers organize and promote the plan.\(^\text{43}\) In the carrier model, insurance companies develop the plan by contracting with the providers and marketing the plan to employers.\(^\text{44}\) Finally, in the broker model, independent agents contract with multiple providers.\(^\text{45}\) They then sell "access to these networks [of medical providers] to insurance companies and self-insured employers."\(^\text{46}\)

**II. LIABILITY AND MCOS**

**A. Hospital Liability: The Foundation**

Malpractice litigation against healthcare providers can be pursued through both vicarious and direct liability.\(^\text{47}\) Vicarious liability is derived from the theories of respondeat superior\(^\text{48}\) and ostensible agency,\(^\text{49}\) while direct liability is premised on

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40. *Id.* at 452-53.
41. *See id.* at 453.
42. Parise, *supra* note 25, at 982.
43. *See id.*
44. *See id.*
45. *See id.*
46. *Id.* at 982-83.
48. Respondeat superior is a form of vicarious liability in which the employer is liable for the negligence of its employees acting within the scope of their employment. *See BLACK'S LAW DICTIONARY* 1311-12 (6th ed. 1990).
49. Ostensible agency is another form of vicarious liability “where one, either intentionally or from want of ordinary care, induces another to believe that a third person is his agent, though he never in fact employed him.” BLACK'S LAW DICTIONARY 1100 (6th ed. 1990).
corporate negligence, negligent provider selection, and negligent provider control.  

1. Vicarious Liability and Hospitals: Respondeat Superior

Traditionally, courts treated hospitals as charitable institutions and found them immune from direct and vicarious liability. Until recently, courts exempted hospitals from vicarious liability because nurses and doctors were considered independent contractors rather than employees. The New York Court of Appeals in Schloendorff v. Society of New York Hospital defined this rule, stating that medical professionals were independent contractors because of their expertise and the fact that hospitals do not control their actions. This theory was accepted until the same court in Bing v. Thunig rejected the concept of hospital immunity by ruling that the status of a physician’s relationship to the hospital subjected it to the same rules of respondeat superior that applied to other employers. The court noted that hospitals employ salaried physicians as well as charge and collect medical fees for delivered services.

Recently, the New York Court of Appeals restated the respondeat superior principle for hospitals in Hill v. St. Claire’s Hospital. The court ruled that a hospital or medical facility is liable for the negligence of its employees, but will not be held liable if its providers are independent contractors or if the patient independently retains the physician. Factors used to determine whether a physician is an independent contractor or an employee include the manner in which the physician was hired, whether an employment contract exists, whether the hospital exerts control over the physician, the degree of skill of the physician’s work, whether the physician is paid hourly or by

50. See Chittenden, supra note 31.
53. Id.
54. See id. at 93-95.
55. 143 N.E.2d 3 (N.Y. 1957).
56. See id. at 9.
57. See id. at 8.
58. See id.
60. See id. at 827.
the job, whether the hospital may discharge the physician, and whether the hospital owns the medical facility.61

2. Vicarious Liability: Ostensible Agency

Once the New York Court of Appeals subjected hospitals to respondeat superior under Bing v. Thunig,62 courts began to apply other forms of vicarious liability, such as ostensible agency, to medical institutions.63 The New York Court of Appeals in Mduba v. Benedictine Hospital64 used an ostensible agency analysis to find a hospital liable for the negligence of an independent contractor.65 There, the court ruled that the hospital held itself out to the public as an institution providing physicians, staff, and facilities.66 Later, the Supreme Court of Alaska in Jackson v. Power67 defined two factors relevant to a “finding of ostensible agency: (1) whether the patient looks to the institution, rather than the individual physician, for care; and (2) whether the hospital ‘holds out’ the physician as its employee.”68

64. 384 N.Y.S.2d 527.
65. See id. at 529-30.
66. See id.
67. 743 P.2d 1376.
68. Id. at 1380; see Hardy, 471 So. 2d at 370 (ruling that when a hospital offers medical services to public and patient receives healthcare without choosing physician, ostensible agency doctrine applies).
3. Direct Liability

The extension of vicarious liability to hospitals led to the application of direct liability to hospitals.\(^6^9\) In *Darling v. Charleston Community Memorial Hospital*,\(^7^0\) the Illinois Supreme Court ruled that a hospital has the duty to monitor the quality of healthcare delivered by physicians who may not be employees of the hospital.\(^7^1\) The imposition of an independent responsibility to monitor physicians is referred to as “corporate negligence” because the medical personnel are considered part of the corporation “whether they were staff employees or independent contractors.”\(^7^2\) Subsequent cases reaffirm the *Darling* court’s creation of a direct duty to monitor physicians by using a corporate negligence theory to find the hospital liable for the patient’s injuries.\(^7^3\)

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69. See Furrow ET AL., supra note 24, at 248.
71. See id. at 258.
72. Furrow ET AL., supra note 24, at 248.
73. See Parise, supra note 25, at 990; see also Fridena v. Evans, 622 P.2d 463 (Ariz. 1980) (ruling that if hospital had notice of employees’ actions, it may be liable for negligent supervision); Tuscon Med. Ctr. v. Misevch, 545 P.2d 958 (Ariz. 1976) (implying that hospitals may be held liable for injuries resulting from negligent supervision of their staff); Purcell v. Zimbelman, 500 P.2d 335 (Ariz. Ct. App. 1972) (stating that hospitals have duty to supervise competence of their staff doctors); Elam v. College Park Hosp., 183 Cal. Rptr. 158 (Cal. Ct. App. 1982) (concluding that duty to investigate may require full investigation and continuous review and evaluations of staff); Insinga v. LaBella, 543 So. 2d 209 (Fla. 1989) (recognizing hospital’s duty to use due care in selection and retention of physicians on staff); Joiner v. Mitchell County Hosp. Auth., 186 S.E.2d 307, 125 Ga. App. 1 (1971), aff’d, 189 S.E.2d 412 (Ga. 1972) (extending duty to exercise reasonable care to hospital’s decision to grant staff privileges); Ravenis v. Detroit Gen. Hosp., 234 N.W.2d 411 (Mich. Ct. App. 1975) (holding that hospital failed to provide complete medical records to resident physicians and was liable for injuries sustained by patient); Felice v. St. Agnes Hosp., 411 N.Y.S.2d 901 (N.Y. App. Div. 1978) (concluding that hospital can be liable for actions of independent contractor physician because hospitals have duty to ensure that physicians comply with their standards and regulations); Thompson v. Nason Hosp., 535 A.2d 1177 (Pa. Super. Ct. 1988), aff’d, 691 A.2d 703 (Pa. 1991) (holding that hospital can be negligent in failing to supervise quality of care or competence of its staff); Johnson v. Misericordia Community Hosp., 301 N.W.2d 156 (Wis. 1981) (noting that hospital has duty to exercise due care in selection of its medical staff).
B. Extension of Liability to MCOs Whose Services Are Not Employer-Sponsored

1. Vicarious Liability: Respondeat Superior

Because MCOs are providers of medical services similar to hospitals, courts have imposed vicarious liability on these entities for the negligence of physicians under their employ or with whom they contract. The manner in which an MCO is organized determines the amount of control an MCO exerts over its providers and whether vicarious liability is applicable.

In the staff model, vicarious liability can be established by applying traditional respondeat superior theories. The Indiana Court of Appeals in Sloan v. Metropolitan Health Council used this theory to find an HMO liable for the physician's failure to diagnose. The court ruled that the HMO's medical director controlled the physician, and the doctor performed an act within the scope of his employment. Additionally, the District of Columbia Circuit Court in Schleier v. Kaiser Foundation Health Plan used the doctrine of respondeat superior to find a staff model HMO liable for the acts of an independent contractor. The court ruled that the HMO controlled the physician's behavior because he reported to an HMO doctor.

The Schleier decision affects the liability analysis for both the IPA and PPO forms of managed care because the court found an HMO liable for the negligent acts of a non-employee, independent contractor. Although PPOs and IPAs do not directly employ physicians, they still exert control over physicians' medical decisions by implementing internal "cost-control mechanisms" such as diagnosis protocols and utilization review. A PPO or

74. See Parise, supra note 25, at 991.
75. See Anne Maltz, Managed Care Organizations and Vicarious Liability, N.Y.L.J., Aug. 12, 1996, at 1, 2.
76. See Chittenden supra note 31, at 455; Maltz supra note 75, at 2.
78. See id. at 1109.
79. See id.
80. 876 F.2d 174 (D.C. Cir. 1989).
81. See id. at 177.
82. See id. at 177-78.
83. See Chittenden, supra note 31, at 456.
IPA may be found liable for the acts of physicians with whom they contract because these physicians may have to report to the PPO or IPA to comply with the cost-control mechanisms. Thus, the courts must conduct a case-by-case analysis of claims against IPAs and PPOs to determine whether respondeat superior may be used to hold an IPA or PPO liable for the negligent acts of participating physicians.

2. Vicarious Liability: Ostensible Agency

Although applying the respondeat superior theory to IPA or PPO models is more difficult because these models do not directly employ physicians, liability may be more easily imposed on these models through an ostensible agency theory. Because HMOs market themselves as medical institutions offering healthcare services to the public, much like hospitals market their emergency and specialty services to the public, courts have extended ostensible agency theories to these managed care institutions. Further, members of MCOs look to the institution to provide them with a physician or a list of physicians from which to choose, much like patients look to hospitals to provide physicians for emergency medical services. Because of the similarities, courts have often applied ostensible agency theory to MCOs.

The Pennsylvania Superior Court in Boyd v. Albert Einstein Medical Center was the first court to apply an ostensible agency to an MCO. The court in Boyd noted the changing role of healthcare providers and ruled that the rationale for applying ostensible agency to hospitals also applies to the IPA model HMO. Additionally, the Sixth Circuit in Decker v. Saini

85. See Parise, supra note 25, at 996-97.
86. See Chittenden, supra note 31, at 459-60.
87. See id. at 460-61.
88. See id.
90. See Parise, supra note 25, at 997.
91. See Boyd, 547 A.2d at 1234; see also Dunn v. Prass, 606 A.2d 862 (N.J. Super. Ct. App. Div. 1992). In Dunn, the court noted all of the actions the HMO took to hold out the physician as one of its employees and to induce the patient to look toward the institution as the provider of services. See Dunn, 606 A.2d at 868-69 & n.4. The court mentioned the HMO's advertising, the 24-hour service center, the examinations that were held at the HMO facilities, and the physicians lack of control over the selection of their patients. Id. at 869 n.4.
recognized policy reasons for extending ostensible agency to MCOs, stating, "it would be against public policy to allow HMOs . . . to escape liability for their members' treatment." Although the decision in Boyd involved an IPA, courts will likely extend ostensible agency to PPOs and other HMOs because members look to the institutions for a list of approved providers rather than freely selecting their own physicians.

3. Direct Liability

Because MCOs are subject to vicarious liability, courts have also extended direct liability such as corporate negligence to these entities. The development of direct liability for hospitals is instrumental in extending an independent duty to MCOs. Recently, courts have imposed direct liability on hospitals for negligent selection and retention of physicians and medical staff. When MCOs take over the selection of providers, they, like hospitals, should be held liable when they hire incompetent physicians. The Missouri Supreme Court in Harrel v. Total HealthCare, Inc. was the first court to address what duties MCOs owe their members. There, the court held that a HMO's limitation on available providers for its members creates a duty of care in the selection and retention of its participating providers. The Superior Court of Pennsylvania in McClellan v. Health Maintenance Organization found that an IPA model

(declaring that ostensible agency may apply when MCO holds physician out as its employee).

93. See id. at 35.
95. See id. at 399-400.
96. See Chittenden, supra note 31, at 468-69.
97. See supra notes 63-68 and accompanying text.
98. See Dorros & Stone, supra note 94, at 400.
99. 781 S.W.2d 58 (Mo. 1989).
100. See Dorros & Stone, supra note 94, at 397.
101. See Harrel, 781 S.W.2d at 59-60; see also Insinga v. LaBella, 543 So. 2d 209 (Fla. 1989) (finding HMO liable on corporate negligence theory). Even though the Missouri Supreme Court later upheld a state statute that denied recovery for the plaintiff in Harrel, it is significant that the Missouri Court of Appeals stated MCOs have a duty of care in selecting its physicians. See Dorros & Stone, supra note 94, at 397.
HMO also has a duty to select competent physicians and to monitor the quality of care.\textsuperscript{103}

Finally, decisions from the California Court of Appeals in both \textit{Wickline v. State}\textsuperscript{104} and \textit{Wilson v. Blue Cross}\textsuperscript{105} indicate that an MCO may have a duty of care in making medical decisions based on utilization review.\textsuperscript{106} In \textit{Wickline}, the court found that the California state Medicaid program did not have a duty of care in the utilization review because it was following statutory requirements for cost containment.\textsuperscript{107} However, in dicta the court stated, "[t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms..."\textsuperscript{108} Additionally, the court in \textit{Wilson} held that a private insurer or utilization review company will be liable for injuries resulting from defects in the design or implementation of utilization review programs.\textsuperscript{109} The court in \textit{Wilson} distinguished the \textit{Wickline} decision.\textsuperscript{110} It announced that \textit{Wickline} was an exception to provider liability because there the state statutes required the Medicaid program to implement cost-containment measures and exempted the Medicaid program from tort liability as long as the medical decisions were made in accordance with community standards.\textsuperscript{111}

III. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

A. History

Congress enacted ERISA to "assur[e] the equitable character" and "financial soundness" of employee welfare benefit plans.\textsuperscript{112} When ERISA was enacted in 1974, state laws regulating employee benefits plans were varied and inconsistent.\textsuperscript{113} Congress was concerned that inconsistent state and federal

\begin{flushright}
103. See id. at 1058-59.
106. See \textit{Wickline}, 228 Cal. Rptr. at 670-71; \textit{Wilson}, 271 Cal. Rptr. at 879.
107. See \textit{Wickline}, 228 Cal. Rptr. at 670-71.
108. \textit{Id.} at 670.
110. See id. at 879.
111. See id.
113. See Dorros & Stone, supra note 94, at 400 n.156.
\end{flushright}
regulations for employee benefit plans would lead to financial instability and prevent employees from claiming benefits when they retired. While Congress considered the protection of employees, it also recognized the need to minimize burdens on employers who voluntarily set up employee benefit plans. With a uniform federal law regulating employee benefit plans, Congress hoped ERISA would encourage more employers to fund their own health plans.

B. Pertinent Provisions of ERISA

1. Section 3(1)

ERISA section 3(1) broadly defines “employee welfare benefit plan” as “any plan or program established by an employer for the purpose of providing medical care or benefits to its employees, through the purchase of insurance or otherwise.” Thus, an employer-funded health plan operating through an MCO qualifies as a plan regulated by ERISA.

2. Section 502(a)

ERISA’s civil enforcement provision, Section 502(a), provides members of benefit plans with a private cause of action against their insurer concerning the delivery of benefits. Under Section 502(a)(1)(B), a plan member can bring a civil action in federal or state court to “recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” Once a claim is made, the court

114. *See id.*
115. *See Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 10 (1987).*
116. *See Kilcullen, supra note 26, at 9.*
120. *See Shah, supra* note 21, at 1552-55.
121. 29 U.S.C. § 1132(a)(1)(B) (1994). This section states:

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section 
[concerning request to a plan administrator for information], or 

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to
determines if the cause of action falls into one of these three categories of complaints. If the claim meets one of the requirements, it is completely preempted by ERISA.

3. Section 514(a) and the Savings Clause

Section 514(a) is another preemption provision among ERISA’s enforcement clauses, which expressly states that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” The meaning of the preemption provision is broad, and courts have encountered difficulty interpreting the meaning of the phrase “relates to.” The Supreme Court in Shaw v. Delta Airlines decided that a state law “relates to” an employee benefit plan if it has “a connection with or reference to such a plan.” But the Supreme Court added that the relationship may not be “too tenuous, remote or peripheral.” In Metropolitan Life Insurance Co. v. Massachusetts, the Supreme Court also ruled that a state law is not precluded from preemption even if it is consistent with ERISA’s regulations. Nonetheless, an exception to Section 514(a), referred to as the “savings clause,” allows state laws regulating insurance to circumvent preemption. The Supreme Court in Metropolitan relied on the McCarran-Ferguson Act to determine which

clarify his rights to future benefits under the terms of the plan.

Id. § 1132(a).
122. See Shah, supra note 21, at 1552-55.
125. Id.
129. See id. at 96-97.
130. Chittenden, supra note 31, at 486.
132. See id. at 739.
133. Chittenden, supra note 31, at 486.
state laws regulate insurance.\textsuperscript{136} Thus, if a cause of action is based on a state law regulating insurance, then the claim will not be preempted and is saved.\textsuperscript{137}

IV. ERISA AS A DEFENSE TO MANAGED CARE LIABILITY

As discussed in Part III, ERISA regulates any claim for the enforcement, recovery, or clarification of health benefits under employer-sponsored plans.\textsuperscript{138} Further, ERISA preempts any claim based on state law that relates to an employer benefit plan.\textsuperscript{139} Members of MCO plans that are not sponsored by employers can bring malpractice claims against MCOs on the basis of either vicarious or direct liability.\textsuperscript{140} Because of the breadth of the preemption clauses, ERISA usually preempts claims for provider malpractice against employer-sponsored MCO plans.\textsuperscript{141}

Prior to \textit{Dukes v. U.S. Healthcare, Inc.},\textsuperscript{142} all circuit courts held that ERISA completely preempted claims based on direct liability against employer-sponsored MCO plans.\textsuperscript{143} However, the district courts are split as to whether an employer-sponsored MCO plan can be held vicariously liable for provider negligence.\textsuperscript{144} The Third Circuit in \textit{Dukes v. U.S. Healthcare, Inc.} examined a vicarious liability negligence claim against an employer-sponsored MCO.\textsuperscript{145}

A. ERISA Preemption: Direct Liability Claims Against MCOs

Every circuit and district court that has considered direct malpractice negligence claims against employer-sponsored MCOs has uniformly held that ERISA preempts such claims.\textsuperscript{146}

\textsuperscript{136} See \textit{Metropolitan Life}, 471 U.S. at 743-47.
\textsuperscript{137} See id. The section states, “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . .” 29 U.S.C. § 1144(b)(2)(A) (1994).
\textsuperscript{139} See id. § 1144(a).
\textsuperscript{140} See supra notes 74-111 and accompanying text.
\textsuperscript{141} See Kilcullen, supra note 26, at 9.
\textsuperscript{142} 57 F.3d 350 (3d Cir. 1995).
\textsuperscript{143} See Chrys A. Martin, \textit{Developments in Managed Care}, SA93 ALI-ABA 217, 221 (1996).
\textsuperscript{144} See id. at 223.
\textsuperscript{146} See Martin, supra note 143, at 221. For District Court analysis, see Stroker v. Rubin, No. 94-5583, 1994 WL 719694 (E.D. Pa. Dec. 22, 1994) (ruuling that claims
Recently, the Tenth Circuit addressed a wrongful death claim against an insurer in *Settles v. Golden Rule Insurance Co.* 147 and ruled that ERISA preempts claims for wrongful death based on the termination of coverage because they are adjudicated under state common law relating to health plans.148 Additionally, both the Eighth Circuit in *Kuhl v. Lincoln National Health Plan* 149 and the Fifth Circuit in *Corcoran v. United HealthCare, Inc.* 150 also found that ERISA preempts state claims for medical malpractice and wrongful death against HMOs that administer employer-funded plans.151 Both circuit courts held that denial of benefits based on utilization review decisions are administrative choices relating to the availability plan benefits.152 Thus, these tort claims were completely preempted against HMO for negligent selection and wrongful death were preempted by ERISA; Nealy v. U.S. Healthcare HMO, 844 F. Supp. 966 (S.D.N.Y. 1994) (holding that claims for wrongful death and malpractice are preempted by ERISA because they affect administration of plan); Kohn v. Delaware Valley HMO, Inc., No. 91-2745, 1991 WL 275609 (E.D. Pa. Dec. 20, 1991) (holding that claim charging HMO for negligent failure to provide funding is related to the plan and preempted).

147. 927 F.2d 505 (10th Cir. 1991).
148. See id. at 509-10; see also Tolton v. American Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995) (ruling that state law claims for wrongful death are related to ERISA plan); Anderson v. Humana, Inc., 24 F.3d 899 (7th Cir. 1994) (concluding that ERISA preempted employee's claims of violation of state anti-deception law and fraudulent deception concerning plan options); Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993) (holding that ERISA preempted state law wrongful death cause of action, and sole exception to ERISA preemption for state laws that regulate insurance did not apply to state common-law wrongful death claim).

Federal district courts have consistently ruled that ERISA preempts direct negligence claims against insurers and MCOs. See Pomero v. Johns Hopkins Med. Servs., Inc., 868 F. Supp. 110 (D. Md. 1994) (finding that state law claims for negligence and intentional infliction of emotional distress were related to plan and preempted by ERISA); Diaz v. Texas Health Enter., Inc., 822 F. Supp. 1255 (W.D. Tex. 1993) (holding that claim for negligence is related to plan and is preempted); Altieri v. Cigna Dental Health, Inc., 753 F. Supp. 61 (D. Conn. 1990) (holding that ERISA preempted negligence claims against administrator of employee benefit plan for failing to evaluate competence of doctor); Holmes v. Pacific Mut. Life Ins. Co., 706 F. Supp. 733 (C.D. Cal. 1989) (concluding that wrongful death claim against plan administrator resulting from delay in treatment was preempted by ERISA).

149. 999 F.2d 298 (8th Cir. 1993). In *Kuhl*, the plaintiff claimed that the HMO’s delay in approving heart surgery for her spouse caused his death. See id. at 300.
150. 965 F.2d 1321 (5th Cir. 1992), cert. denied, 506 U.S. 1033 (1992). In *Corcoran*, the plaintiffs claimed the HMO negligently denied appropriate medical care under their utilization review program, which caused the wrongful death of their unborn child. See id. at 1324.
151. See *Kuhl*, 999 F.2d at 300-01; *Corcoran*, 965 F.2d at 1331.
152. See *Kuhl*, 999 F.2d at 302-03; *Corcoran*, 965 F.2d at 1332.
because “the administration of plan benefits” fall within ERISA’s purview.\textsuperscript{153}

B. Vicarious Liability Claims Against MCOs

Federal “district courts disagree [as to] whether ERISA preempts indirect negligence claims” based on theories of ostensible agency and respondeat superior.\textsuperscript{154} The United States District Court of New Jersey in Butler v. Wu\textsuperscript{155} and Ricci v. Gooberman\textsuperscript{156} found that ERISA preempted state law claims based on vicarious liability. The District Court in Butler found that an HMO managed, employer-sponsored plan was vicariously liable for the negligence of providers when the HMO acts more like a traditional insurer rather than a provider of healthcare services.\textsuperscript{157} Further, the United States District Court of Maryland in Pomeroy v. Johns Hopkins Medical Services\textsuperscript{158} pronounced a general rule that ERISA preempts all “medical malpractice claim[s] against an HMO, whether couched in direct or vicarious liability terms,” because the claims relate to the plan.\textsuperscript{159}

Conversely, other district courts have ruled that ERISA does not preempt vicarious liability claims against HMOs.\textsuperscript{160} The Third Circuit in Dukes v. U.S. Healthcare, Inc. was the first circuit court to address whether an HMO may be held vicariously liable for the negligence of its providers and pronounced a new test for determining whether ERISA preempts state law malpractice claims.\textsuperscript{161}

\begin{footnotesize}
\begin{enumerate}
\item[153.] Shah, \textit{supra} note 21, at 1560 n.79; see also \textit{Spain}, 11 F.3d at 131.
\item[154.] Shah, \textit{supra} note 21, at 1560-61.
\item[156.] 840 F. Supp. 316 (D.N.J. 1993).
\item[157.] \textit{See Butler}, 853 F. Supp. at 129-30.
\item[158.] 868 F. Supp. 110 (D. Md. 1994).
\item[159.] \textit{Id.} at 113-14.
\item[161.] \textit{See Dukes v. U.S. Healthcare, Inc.}, 57 F.3d 350 (3d Cir. 1995).
\end{enumerate}
\end{footnotesize}
V. DUKES V. U.S. HEALTHCARE, INC.: A WAY AROUND ERISA

A. Complete Preemption Doctrine

In Dukes, the Third Circuit discussed application of the complete preemption doctrine\(^{162}\) and its relation to ERISA.\(^{163}\) The court discussed the Supreme Court's ruling in Franchise Tax Board v. Construction Laborers Vacation Trust,\(^{164}\) which stated that the complete preemption doctrine applies when "the preemptive force of a [federal statute] is so powerful as to displace entirely any state cause of action" addressed by the federal statute.\(^{165}\) Additionally, the Supreme Court ruled that complete preemption applies even if state law provides a cause of action in the absence of a federal provision.\(^{166}\) In an earlier case, the Court acknowledged that under the complete preemption doctrine, "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character."\(^{167}\)

The Supreme Court in Pilot Life Insurance Co. v. Dedeaux\(^{168}\) ruled that state law claims that fit within the scope of ERISA's civil enforcement provision, Section 502,\(^{169}\) are completely preempted.\(^{170}\) These provisions provide that a civil action may be brought to "recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits."\(^{171}\) The Third Circuit in Dukes noted that ERISA's legislative history indicates that Congress intended to make Section 502 completely preemptive, similar to Section 301 of the Labor Management Relations Act.\(^{172}\)

The Dukes court also defined the difference between preemption and complete preemption.\(^{173}\) If a state claim is based on the enforcement, recovery, or clarification of benefits,

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162. See id. at 354-55.
163. See id.
165. Id. at 23.
166. See id.
171. Id. at 53.
173. See id. at 355.
1998] PREEMPTION OF ERISA UNDER DUKE V. U.S. HEALTHCARE 943

the doctrine of complete preemption applies under Section 502.\textsuperscript{174} If the claim is not preempted under Section 502, the court must remand the case to state court to determine whether section 514(a), the “relate to” clause, preempts the claim.\textsuperscript{175}

Formerly, a negligence claim based on vicarious liability against an HMO administering an employer-funded plan may have been completely preempted, which enabled the case to be instantly removed to federal court and precluded the state courts from hearing the case and addressing the state law issues.\textsuperscript{176} Now, under the \textit{Dukes} test, a negligence claim based on vicarious liability is neither completely preempted nor automatically removed to federal court.\textsuperscript{177} Thus, state courts at least get an opportunity to examine the case, and local plaintiffs may feel they have a better chance to succeed on the merits of a case that involves state law issues in a state court.\textsuperscript{178}

B. What is a Benefit?

After explaining the distinction between the complete preemption doctrine, which applies to claims arising under Section 502(a), and regular preemption, which applies to claims arising under Section 514, the \textit{Dukes} court determined whether medical malpractice state claims concern the recovery, enforcement, or clarification of benefit rights.\textsuperscript{179} The plaintiffs argued that the sole benefit received was membership in the plan.\textsuperscript{180} U.S. Healthcare argued that, because a negligent treatment claim is actually about receiving a benefit, the

\textsuperscript{174} See id. at 356.
\textsuperscript{175} See id. at 354-55 (citing Franchise Tax Bd. v. Construction Laborers Vacation Trust, 463 U.S. 1, 4, 27-28 (1983); Warner v. Ford Motor Co., 46 F.3d 531, 533-35 (6th Cir. 1995); Lupo v. Human Affairs Intl., Inc., 28 F.3d 269, 274 (2d Cir. 1994)).
\textsuperscript{177} See Dukes, 57 F.3d at 355. The \textit{Dukes} court rejected the district court’s decision that the vicarious liability claims did not automatically fall within Section 502 of ERISA. See id. The court asked to examine “the relationships among the HMO, the employer, and the other defendants, the nature of the plan benefits, and the rights of participants and beneficiaries under the plan.” Id. at 356.
\textsuperscript{179} See Dukes, 57 F.3d at 356.
\textsuperscript{180} See id.
definition of benefit is the medical care itself. Therefore, according to U.S. Healthcare, ERISA preempts both the ostensible agency and direct negligence claims under Section 502 because such claims concern the receiving, enforcement, or clarification of benefits. The court decided that the definition of a benefit is not a determinative factor and assumed that a benefit is the medical care instead of merely HMO membership.

C. Quality of Benefits: The Distinguishing Mark

The Third Circuit noted that nothing in the plaintiffs' complaints mentions denial, enforcement, or clarification of benefits rights. The Third Circuit stated that even if benefits were construed as U.S. Healthcare requested, the plaintiffs' claims "merely attack the quality of the benefits they received" and do not allege that the plan "erroneously withheld benefits due." The court noted that the complaints did not allege U.S. Healthcare refused to pay or provide services; the complaints only addressed the low quality of care received. Additionally, the court ruled that the plaintiffs did not allege the quality was so low that it could be construed as a denial of benefits. Thus, U.S. Healthcare could not argue that the plaintiffs were trying to recover benefits due them under Section 502.

Further, the court rejected U.S. Healthcare's broad-based argument that the plaintiffs were trying to enforce their rights. The court noted this phrase was meant to apply to any contract rights set out in the summary plan description such as claim and eligibility procedures, and not to the right to medical benefits.

181. See id.
182. See id.
183. See id.
184. See id. at 356-57.
185. Id. at 356.
186. Id.
187. See id. at 356-57.
188. See id. at 358.
190. See Dukes, 57 F.3d at 357.
191. See id.
The court also rejected U.S. Healthcare’s argument that plaintiffs were “attempt[ing] to define a participant’s rights under the plan.” The Third Circuit stated that the plaintiffs were not trying to define new rights, but were “attempting to assert their already-existing rights under the generally-applicable state law of agency and tort.” The court stated, “patients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan.” The court noted that the plaintiffs did not request clarification of a future benefit in their complaint.

Because the plaintiffs’ claims fell outside the scope of Section 502(a), they should not have been completely preempted and automatically removed to federal court. Additionally, the court relied upon Lupo v. Human Affairs International, Inc. to support its contention that complete preemption is inappropriate when the face of the claim contains no cause of action arising under Section 502. The court did not address the application of Section 514, but remanded the case to the state court to do so.

D. Legislative Intent

The court noted that legislative history does not reveal any intent by Congress that ERISA should serve as a remedy for plan participants injured by medical malpractice. The court stated that ERISA is concerned with the “funding and payment of plan benefits.” The statute states that ERISA was enacted because “the inadequacy of current minimum... standards, [and because] the soundness and stability of plans with respect to adequate funds to pay promised benefits [might] be endangered.” Thus, Section 502 was meant to provide a

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192. Id. at 358.
193. Id.
194. Id.
195. See id.
196. See id. at 357-61.
197. 28 F.3d 269 (2d Cir. 1994).
198. See Dukes, 57 F.3d at 361.
199. See id.
200. See id. at 357.
201. Id.
202. Id. (quoting 29 U.S.C. § 1001(a) (1994)).
remedy for beneficiaries when their plans did not meet their financial commitments. 203

The court then analyzed the history behind Section 502, but did not find text indicating this section was intended to serve as a federal means for controlling the quality of benefits received. 204 The court also relied upon the Supreme Court ruling in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co. 205 to conclude that Congress did not intend ERISA to control the quality of healthcare benefits delivered to recipients. 206 The court used the Supreme Court's logic, stating "that while quality standards and work place regulations in the context of hospital services will indirectly affect the sorts of benefits an ERISA plan can afford, they have traditionally been left to the states, and there is no indication in ERISA that Congress chose to displace general health care regulation by the states." 207 The Third Circuit ruled that states traditionally regulate the quality of healthcare benefits and stated, "we interpret the silence of Congress as reflecting an intent that it remain such." 208

E. Reconciling the Past

The Third Circuit reconciled its decision in Dukes—that ERISA does not preempt vicarious liability claims—with other circuit court decisions, which hold that ERISA does preempt direct negligence claims based on utilization review. 209 The Dukes court stated its ruling was consistent with the Fifth Circuit's analysis in Corcoran v. United Healthcare, Inc. 210 and the Eighth Circuit's decision in Kuhl v. Lincoln National Health Plan. 211 Both of these decisions allowed ERISA to preempt medical malpractice claims based on utilization review determinations. 212 The Dukes court noted that claims based on

203. See id.
204. See id.
206. See Dukes, 57 F.3d. at 357.
207. Id.
208. Id.
209. See id. at 360-61.
210. 965 F.2d 1321 (5th Cir. 1992).
211. 999 F.2d 298 (8th Cir. 1993).
212. See Dukes, 57 F.3d at 359-61. The court also cited several District Court decisions that allowed ERISA to preempt vicarious and direct liability claims for
a denial of treatment due to utilization review concern recovering benefits, which fall under the purview of Section 502(a)(1)(B) and are completely preempted.\textsuperscript{213} The court explained that utilization review determinations are similar to common-law claims arising from improper claims processing, which ERISA completely preempts under Section 502.\textsuperscript{214} The court explained that although utilization review decisions are part of the medical decisionmaking process, they are merely administrative decisions and do not involve the selection and supervision of physicians delivering medical treatment.\textsuperscript{215} Because utilization review does not select the physicians, the decisions are administrative and are completely preempted by Section 502.\textsuperscript{216}

In support of its decision, the court cites district court rulings in \textit{Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine Parkview Division},\textsuperscript{217} \textit{Kearney v. U.S. Healthcare, Inc.},\textsuperscript{218} and \textit{Independence HMO, Inc. v. Smith},\textsuperscript{219} which all found that ERISA did not preempt vicarious liability claims concerning the level of care received from providers.\textsuperscript{220}

\textit{F. Policy Implications}

\textit{1. Quality}

Through the use of the complete preemption doctrine, federal courts have essentially eliminated direct negligence claims against employer-sponsored HMO plans.\textsuperscript{221} Thus, extending the complete preemption doctrine to vicarious liability claims based

\begin{itemize}
  \item See \textit{id.} at 360-61.
  \item See \textit{id.}
  \item See \textit{id.}
  \item See \textit{id.}
  \item 859 F. Supp. 182 (E.D. Pa. 1994) (holding that ERISA does not preempt vicarious liability claim based on ostensible agency for negligent actions of HMO's physician).
  \item 733 F. Supp. 983 (E.D. Pa. 1990) (holding that ERISA did not preempt medical malpractice claim against HMO based on ostensible agency).
  \item See Shah, \textit{supra} note 21, at 1574.
\end{itemize}
on provider negligence would eliminate the only remaining
theory for subjecting employer-sponsored HMO plans to tort
liability.\textsuperscript{222} To hold some HMO plans, but not employer-
ponsored HMO plans, to tort liability is "inherently inequitable."\textsuperscript{223} Further, immunizing employer-sponsored HMO
plans from tort liability eliminates a vital deterrent because it no
longer prevents healthcare providers from hiring incompetent
physicians.\textsuperscript{224} Without the deterrent effect of tort liability, the
quality of medical care may decline because HMOs will be less
concerned about the actions of their physicians.\textsuperscript{225}

2. Access

ERISA immunity from vicarious liability claims is inequitable
because HMOs often remove doctors from the decisionmaking
process concerning medical care.\textsuperscript{226} If HMOs participate in
medical decisions, they should be exposed to malpractice
liability.\textsuperscript{227} Employer-sponsored HMOs should not force
physicians to bear the entire liability for medical decisions
participated in or controlled by HMOs.\textsuperscript{228} If physicians are held
liable for medical decisions they do not solely control, then their
malpractice insurance premiums, which increase as the number
of malpractice claims increase, may force physicians to leave the
medical practice.\textsuperscript{229} Thus, access to medical care may decline
because doctors will not want to bear all of the liability and
accompanying cost resulting from medical decisions made by
HMOs.\textsuperscript{220}

3. Cost

Those who oppose extending vicarious liability to MCO-
managed ERISA plans argue that costs will rise because of the
increased medical malpractice claims against MCOs. MCOs will then pass these costs onto their members in the form of increased premiums. Further, paying legal judgments risks depleting the funds in healthcare plans. However, if malpractice liability is extended to the MCO-managed employer-funded plans, it will deter MCOs from hiring incompetent physicians and will ensure that they scrutinize the medical decisions of physicians as well as their participation in such decisions. Applying a standard of care in these hiring decisions will increase quality of healthcare delivered by MCO physicians, and thus lower costly malpractice claims against MCOs.

VI. DUKES IS OPENING DOORS

A. District Court and Lower Court Cases using the Dukes Logic

Shortly after the ruling in Dukes, the United States District Court for the Eastern District of Pennsylvania followed the Third Circuit’s analysis, by holding, in Whelan v. Keystone Health Plan East, that ERISA does not completely preempt a wrongful death action in which the claim concerns the quality of care received by a decedent. The court noted that because the plaintiff did not allege a denial of benefits, Section 502(a) did not completely preempt his claim for direct negligence against an HMO.

In Howard v. Sasson, the same court found that ERISA does not preempt a negligence claim against an HMO based upon respondeat superior and ostensible agency. The court stated that claims concerning the quality of benefits do not arise under Section 502.

231. See Chittenden, supra note 31, at 489.
232. See id.
233. See id.
234. See Parise, supra note 25, at 1004-05.
235. See Shah, supra note 21, at 1575.
237. See id. at *11.
238. See id.
240. See id. at *2.
241. See id.
Additionally, in Katlin v. Tremoglie, the court relied upon Dukes to rule that a direct negligence claim against an HMO administering an employer-funded plan is not completely preempted by ERISA because the claim does not concern denial of benefits, but rather the quality of healthcare. In Santitoro v. Evans, the court cited the Dukes case in ruling that a malpractice claim based on direct and vicarious liability against an employer-funded HMO is not completely preempted because the claim concerns the quality of care rather than improper benefits processing. Finally, the United States District Court of the Eastern District of Michigan used the Dukes logic in Fritts v. Khoury to determine that a negligence claim against an employer-sponsored HMO does not concern the recovery, enforcement, or clarification of a benefit but rather the quality of care.

In Pappas v. Asbel, the Superior Court of Pennsylvania relied upon Dukes to find that ERISA does not preempt a direct negligence claim because it is “not ‘related to’ the plan.” The court noted that HMO members have the right to be free of medical malpractice regardless of whether their HMO is provided through an ERISA plan. Here, the Dukes logic opened the door to stop preemption under Section 514 as well as Section 502. For example, in Dykema v. King, the United States District Court of South Carolina used the Dukes rationale to hold that a direct or vicarious liability negligence claim against an HMO is not preempted under Section 514.

B. Circuit Courts

In Rice v. Panchal, the Seventh Circuit cited Dukes and held that ERISA does not completely preempt a medical

243. See id. at *2.
244. 935 F. Supp. 733 (E.D.N.C. 1996).
245. See id. at 736.
247. See id. at 671.
249. Id. at 717.
250. See id. (citing Dukes, 57 F.3d at 358).
252. See id. at 740-41.
253. 65 F.3d 637 (7th Cir. 1995).
malpractice claim based upon respondeat superior against a PPO.254 The court noted that the malpractice claim did not state that benefits were denied.255 Moreover, the claim did not rest upon the terms of the ERISA plan and, thus, did not require any interpretation or clarification of the plan benefits.256

CONCLUSION

The Dukes decision is instrumental because the court did not find that ERISA automatically preempted a state tort claim, mandating automatic removal to federal court.257 The court created an analysis that forces courts to examine the substantive issues behind each claim.258 By examining the substantive issues, the Dukes court found that a medical malpractice claim based upon vicarious liability does not fall into Section 502.259 By using the two-part test to determine if a claim is preempted, Dukes opened the door for other federal courts to find that ERISA does not automatically trump state malpractice claims.260 To determine if ERISA preempts, federal courts should first ascertain whether the claim arises under Section 502(a).261 If it does, the complete preemption doctrine applies.262 If it does not, federal courts should remand the claim to state court to determine whether it arises under Section 514.263 This analysis has already led five federal district courts and one circuit court to find that ERISA does not preempt direct negligence claims against employer-sponsored HMO plans.264

254. See id. at 646 & n.10.
255. See id. at 642.
256. See id. at 645.
257. See Dukes, 57 F.3d at 355-56.
258. See id. (noting significance of "the relationships among the HMO, the employer, and the other defendants, the nature of the plan benefits, and the rights of participants and beneficiaries under the plan").
259. See id. at 361.
261. See Dukes, 57 F.3d at 354.
262. See id. at 354-55.
263. See id. at 355.
Additionally, the *Dukes* logic has led one state court and one district court to find that medical malpractice claims are not preempted under Section 514.\textsuperscript{265}

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